ADULT FORENSIC SERVICES INVOICE

Community Mental Health Center	Center #	Month	Year

	Name of Service Recipient	Social Security Number	Date of Evaluation Report	Comprehensive or Screening Evaluation (C or S)	Service Provided	Amount Billed	Amount Approved for Payment by TDMHDD (For TDMHDD use only)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
					TOTAL THIS PAGE		

Name of Person Submitting Claim (Please Print) **Date** **Phone Number**

Name of Forensic Coordinator

TDMHDD Forensic Services Approval **Date**

1=Competency Only
2=Insanity Only
3=Both Competency & Insanity
4=Competency Training X 1
5=Competency Training X 2
6=Competency Training X 3
7=Competency Training X 4
8A= DOC evaluation (comp.& ins.)
8B= DOC evaluation (either comp.or ins.)
9=Additional Mental Health Evaluation
PS= Physician Services
T= Testimony after DOC evaluation